

NEVADA STATE BOARD OF MEDICAL EXAMINERS

FEES FOR ROTATING RESIDENT LIMITED MEDICAL LICENSURE

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten (illegible or incomplete applications will be returned). Applications must be received on single sided white bond paper, 8 1/2" x 11" in size.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

ROTATING RESIDENT LIMITED MEDICAL LICENSURE FEES:

Registration Fee	Criminal Background Investigation Fee		
\$80	\$75	=	\$155.00

You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

The Criminal Background Investigation fee is non-refundable.

Per Nevada Revised Statute 630.161, "The Board shall not issue a license to practice medicine to an applicant who has been licensed to practice any type of medicine in another jurisdiction and whose license was revoked for gross medical negligence by that jurisdiction".

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

**** You may be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.**

**** You may be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a, 13, 19, 26, 27, 28, 29, 30, 31, and 32.**

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the National Practitioner Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

THE FOLLOWING MAY CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

NRS 630.301 Criminal offenses; revocation, suspension or other modification of previous license; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
2. Conviction of violating any of the provisions of [NRS 616D.200](#), [616D.220](#), [616D.240](#), [616D.300](#), [616D.310](#), or [616D.350](#) to [616D.440](#), inclusive.
3. The revocation, suspension, modification or limitation of the license to practice any type of medicine by any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if such malpractice is established by a preponderance of the evidence.
5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when such a failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a national code of ethics adopted by the Board by regulation.
10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.

(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, [766](#); 2003, [2707](#), [3433](#); 2003, 20th Special Session, [264](#), [265](#))

NRS 630.304 Misrepresentation in obtaining or reviewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
 2. Advertising the practice of medicine in a false, deceptive or misleading manner.
 3. Practicing or attempting to practice medicine under another name.
 4. Signing a blank prescription form.
 5. Influencing a patient in order to engage in sexual activity with the patient or with others.
 6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
 7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.
- (Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:
 - (a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.
 - (b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.
 - (c) Referring, in violation of [NRS 439B.425](#), a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.
 - (d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.
 - (e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.
 - (f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.
 - (g) Failing to disclose to a patient any financial or other conflict of interest.
 - (h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for his medical education.
2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of [NRS 636.373](#).

(Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING MAY CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:
Cont.

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of statute or regulation governing practice of medicine; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient; lack of skill or diligence; filing of false report; habitual intoxication; failure to report modification of license in another jurisdiction. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
 2. Engaging in any conduct:
 - (a) Which is intended to deceive;
 - (b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
 - (c) Which is in violation of a regulation adopted by the State Board of Pharmacy.
 3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in [chapter 454 of NRS](#), to or for himself or to others except as authorized by law.
 4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
 5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he is not competent to perform.
 6. Performing, without first obtaining the informed consent of the patient or his family, any procedure or prescribing any therapy which by the current standards of the practice of medicine are experimental.
 7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
 8. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
 9. Failing to comply with the requirements of [NRS 630.254](#).
 10. Habitual intoxication from alcohol or dependency on controlled substances.
 11. Failure by a licensee or applicant to report, within 30 days, the revocation, suspension or surrender of his license to practice medicine in another jurisdiction.
 12. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to [NRS 630.318](#).
- (Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575)

NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
 2. Altering medical records of a patient.
 3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
 4. Failure to make the medical records of a patient available for inspection and copying as provided in [NRS 629.061](#).
 5. Failure to comply with the requirements of [NRS 630.3068](#).
 6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board.
- (Added to NRS by 1985, 2223; A 1987, 199; 2001, [767](#); 2002 Special Session, [19](#); 2003, [3433](#))

NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
 2. Willful failure to comply with:
 - (a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;
 - (b) A court order relating to this chapter; or
 - (c) A provision of this chapter.
 3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of [NRS 439B.410](#).
- (Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

ROTATING RESIDENT LIMITED LICENSE APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT:

_____	a.	APPLICATION: <ul style="list-style-type: none"> <input type="checkbox"/> Properly completed, signed and notarized application, including Applicant Responsibility statement; <input type="checkbox"/> Recent passport quality photograph (at least 2"x 2") attached to application; <input type="checkbox"/> Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 14, 19, 26, 27, 28, 29, 30, 31, and 32; <input type="checkbox"/> Release form - signed and notarized (Form A);
_____	b.	FEES: <ul style="list-style-type: none"> • Proper registration AND criminal background investigation fees – cashier's check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. <p>Note: Criminal background investigation fees are <u>non</u>-refundable;</p>
_____	c.	IDENTITY (Important identity documents will be returned to you via secured mail): <ul style="list-style-type: none"> • U.S. born citizens – Original or Certified Birth Certificate that bears an original seal of the issuing agency (notarized copies are not acceptable); • Foreign born citizens - Original Certificate of Naturalization or current original U.S. Passport; • Non U.S. citizens: Copy of both sides of Alien Registration card; Employment Authorization card; or Visa; • Non U.S. citizens: Copy of foreign passport;
_____	d.	MALPRACTICE: <ul style="list-style-type: none"> • List of Malpractice Insurance Carriers (Form B) if you have answered affirmatively to either of the two malpractice questions #12 and/or #12a on the application for licensure; • Copy of the legal Complaint; • Copy of the Settlement and/or filed Dismissal.
_____	e.	Photocopy of medical school diploma;
_____	f.	Photocopy of current state license;
_____	g.	FINGERPRINTING: <ul style="list-style-type: none"> • Once the application and criminal background investigation fee have been received, a fingerprint card and instructions will be mailed to you. The fingerprint card you receive from the Board contains the necessary account numbers required for processing. The completed card <u>must</u> be returned to the Board as well as the signed Civil Applicant Waiver (included in your application package) prior to licensure. Note: Receipt of the Criminal history background results will not delay licensure.

NOTE: Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name (i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or legal documentation reflecting name change).

TO BE SENT DIRECTLY TO THE BOARD FROM A VERIFYING INSTITUTION:

_____	a.	Letter signed by current "out of state" Program Director verifying Residency program participation and that the applicant is in good standing; letter should include dates of rotation, location of rotation, and name of responsible Nevada licensed supervising physician;
_____	b.	Letter signed by the licensed Nevada supervising physician from a graduate program approved by the Accreditation Council for Graduate Medical Education (ACGME), acknowledging responsibility for the Rotating Resident including dates of rotation(s), address and contact information during scheduled rotation. (NRS 630.265 and NAC 630.130);
_____	c.	MALPRACTICE: Malpractice Claim Verification Request (Form B1) to be completed by appropriate entity and returned directly by the verifying institution to the Board office, if applicable.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

**Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners,
1105 Terminal Way, Ste 301
Reno, NV 89502**

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

○ ○ ○ ○ ○

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name_____

Sign your name_____

Date_____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occur prior to you being granted licensure to practice medicine in the State of Nevada.

Nevada Department of ***Public Safety***

CIVIL APPLICANT WAIVER

NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As an applicant who is the subject of a Federal Bureau of Investigation (FBI) fingerprint-based criminal history record check for a noncriminal justice purpose you have certain rights which are discussed below.

1. You must be notified by the Nevada State Board of Medical Examiners that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.

2. If you have a criminal history record, the officials making a determination of your suitability for the job, license or other benefit for which you are applying must provide you the opportunity to complete or challenge the accuracy of the information in the record. You may review and challenge the accuracy of any and all criminal history records which are returned to the submitting agency. The proper forms and procedures will be furnished to you by the Nevada Department of Public Safety, Records Bureau upon request. If you decide to challenge the accuracy or completeness of your FBI criminal history record, Title 28 of the Code of Federal Regulations Section 16.34 provides for the proper procedure to do so:

16.34 – Procedure to obtain change, correction or updating of identification records.

If after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency.

3. Based on 28 CFR § 50.12 (b), officials making such determinations should not deny the license or employment based on information in the record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.

4. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

5. I hereby authorize the Nevada State Board of Medical Examiners, to submit a set of my fingerprints to the Nevada Department of Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.

In giving this authorization, I expressly understand that the records may include information pertaining to notations of arrest, detainments, indictments, information or other charges for which the final court disposition is pending or is unknown to the above referenced agency. For records containing final court disposition information, I understand that the release may include information pertaining to dismissals, acquittals, convictions, sentences, correctional supervision information and information concerning the status of my parole or probation when applicable.

6. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original.

In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

Applicant's Name:

(PLEASE PRINT LAST, FIRST, MIDDLE)

Address:

Applicant's Signature:

Date:

Submitting Agency:

Nevada State Board of Medical Examiners

Address:

1105 Terminal Way, Ste. 301, Reno, NV 89502

Agency Representative:

Daniels, L. L.

(PLEASE PRINT LAST, FIRST, MIDDLE)

Agency Representative's
Signature:

Daniels, L. L.

Date:

3/1/2013

PHYSICIAN
APPLICATION FOR ROTATING RESIDENT
LIMITED LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Date Received by Board

License No. _____

File No. _____

1105 Terminal Way, Ste. 301, Reno, Nevada 89502 Phone (775) 688-2559

(For Board Use Only)

Identity:

1. Present Legal Name _____
Last First Middle Maiden

List any other name(s) ever used _____

Address:

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov. The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address _____
Street City County State Zip

☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers (_____) (_____) (_____) _____
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth _____ Place of Birth _____ Gender ☐ F ☐ M
(Month / Day / Year) (City, State, Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____ Visa _____

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____
NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

Questions:

For the purposes of the following questions, these phrases or words have these meanings:

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

Medical condition includes physiological, mental or psychological condition or disorder.

Chemical substances is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

**FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT
YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO
YOUR COMPLETED APPLICATION FOR LICENSURE FORM.**

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
_____ Yes _____ No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice or by any other reasonable accommodation?
_____ Yes _____ No _____ N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
_____ Yes _____ No _____ N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
_____ Yes _____ No

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? _____Yes _____No

12a. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? _____Yes _____No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?

(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement \$

Month and year of event precipitating claim:

Month and year of lawsuit or court filing:

Insurance carrier at time:

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)

_____Yes _____No

14. Have you previously applied for medical licensure in Nevada (including a residency program)?

_____Yes _____No

15. List names and addresses of all medical schools attended. SUBMIT A PHOTOCOPY OF YOUR MEDICAL SCHOOL DIPLOMA.

Medical School Name

City/State/Country

Place Where
Instruction Received

Dates of Attendance
From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name

City/State/Country

Exact Date of Issuance

17. List all ACGME* approved graduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.

*Accreditation Council for Graduate Medical Education

Postgraduate
Year
(e.g. PGY1, PGY2, etc.)

Hospital/
Institution

City/State

Specify
(I = Internship or R = Residency)
(F = Fellowship)

Type of
Specialty

Dates of Attendance
From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

18. List all non-ACGME approved Fellowship training programs attended in the United States or Canada.

Institution

City/State

Type of
Fellowship

Dates of Attendance
From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

19. Have you **EVER** been the subject of an investigation (including matters that resulted in no adverse action or outcome to you) have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.)

_____Yes _____No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#:

21. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Step Taken

Date (Mo./Yr.)

Results (Three Digit Scores)

Number of Attempts

22. State your scope of practice / specialty(ies)

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES** (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS).

Board	Specialty Board	Certification #	Date of Certification (Mo./Yr.)

24. Account for, **in chronological order**, all activities since graduation from medical school. ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. (Curriculum Vitae cannot be submitted in lieu of your answer to this question.)

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)	Percent Clinical (%)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

25. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

27. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

(If "Yes," attach explanation on separate sheet.)

28. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?

(If "Yes," attach explanation on separate sheet.)

_____Yes _____No

29. Have you EVER been denied membership, been asked to resign or expelled from a medical society or other professional medical organization?

(If "Yes," attach explanation on separate sheet.)

_____Yes _____No

30. Have you EVER been: a) asked to respond to an investigation, b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?

(If "Yes," attach explanation on separate sheet.)

_____Yes _____No

31. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

(If "Yes," attach explanation on separate sheet.)

_____Yes _____No

32. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (**Please Note:** Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.

_____ Yes _____ No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT LIMITED LICENSE AND/OR ROTATING RESIDENTS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

Applicant: _____

Date: _____

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada via telemedicine and whose physical presence exists outside the state of Nevada or the United States

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

Date: _____

MILITARY SERVICE ATTESTATION

Have you ever served in the United States Military (to include National Guard or Reserves)? _____ Yes _____ No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

If yes, which branch of service did you serve? ☐ Air Force
☐ Army
☐ Navy
☐ Marine Corps
☐ Coast Guard

Military occupation specialty or specialties?

<input type="checkbox"/>	Administration or Personnel	<input type="checkbox"/>	Logistics or Supply
<input type="checkbox"/>	Aviation	<input type="checkbox"/>	Maintenance
<input type="checkbox"/>	Civil Engineering	<input type="checkbox"/>	Medical Services
<input type="checkbox"/>	Communications	<input type="checkbox"/>	Security Forces or Military Police
<input type="checkbox"/>	Infantry or Armor	<input type="checkbox"/>	Other
<input type="checkbox"/>	Legal or Chaplain Corps		

Dates of service in the Military:

From: _____/_____/_____
DD MM YYYY

To: _____/_____/_____
DD MM YYYY

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

Signature of applicant

Date

NEVADA STATE BOARD OF MEDICAL EXAMINERS LICENSURE APPLICATION ATTESTATION

I, _____,
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

Signature of applicant

Date

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____,

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____

City

State

Signature of Notary

END OF APPLICATION

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

A photocopy of this form will serve as an original.

Please return completed form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Suite 301
Reno, NV 89502

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

(If more space is needed, please copy this page or attach a separate sheet.)

Applicant: If you answered affirmatively to questions #12 and #12a on the Application for Licensure, complete both the top portion and release area of this form; have this form notarized, and submit this form to all malpractice carriers verifying coverage within the past 10 years. Copies of this form may be used if you have more than one malpractice carrier.

FORM B1

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insured Physician: _____

Name of Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

.....

To be completed by verifying agency only

Policy Number: _____

Policy Period From: _____ To: _____

**Please provide a loss history report with this verification.

Claims Experience:

Has this Physician had a settlement paid on his/her behalf? _____ Yes _____ No

If "yes", please provide the following information:

<i>Occurrence Date</i>	<i>Status</i>	<i>Date Closed</i>	<i>Indemnity Amount</i>
_____	_____	_____	_____

Description of Claim: _____

Insurance Carrier Agent:

Print Name and Title

Signature of Agent

Telephone

Email address

Please mail completed form to:

Nevada State Board of Medical Examiners

1105 Terminal Way #301

Reno, NV 89502

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the State of Nevada.

Medical Doctor (applicant) signature and date

Subscribed and sworn to before me this _____ day of _____, 2_____,

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____ City _____ State _____

Signature and Seal of Notary Public

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
1105 Terminal Way, Suite 301
Reno, NV 89502
or fax to:
775-688-2321

Please type or print legibly.

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

Phone Number: _____

Credit Card Number: _____

Expiration Date: ____ / ____
 (MM) (YYYY)

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of \$ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____